ARIZONA STATE BOARD OF NURSING

1740 WEST ADAMS STREET SUITE 2000
PHOENIX, ARIZONA 85007-2607
602-771-7800
WEBSITE: AZBN.GOV
PLEASE SEND REPORTS VIA EMAIL TO:
MONITORING@AZBN.GOV
OR USPS TO ADDRESS ABOVE

INDIVIDUAL COUNSELING REPORT

_____ is required to have submitted on his/her behalf, a counselor report and evaluation every_____months. Please complete this form and return it to the address shown above.

Report On: _____
Name of Nurse Receiving Individual Counseling

Type of Counseling/Treatment (check all that apply):

☐ Rehabilitation ☐ Aftercare ☐ Relapse Prevention Therapy
☐ Psychiatric ☐ Psychological ☐ Medical
☐ Other _____

Date of Report:_____Date Counseling Began: _____

Number of Sessions (since the last report) That Were: **Attended**_____**Missed** _____

If Missed, Reasons Given for Absence: _____

Problem Areas Addressed in Counseling: _____

_____

Is this Nurse Making Satisfactory Progress: Δ Yes Δ No

Comments: _____

_____

Referrals or Recommendations Made to Nurse: _____

_____

Compliance with Previous Referrals or Recommendations: _____

_____

_____ _____
Name and Title of Counselor Agency

_____ _____
Signature of Counselor Address

_____ _____ _____
Telephone # City/State Zip